SLEEP HEALTH CLINIC

Phone: (360) 602.1218

Fax: (360) 991.0291

2501 NE 134TH ST, STE 203

VANCOUVER, WA 98686

RELEASE OF INFORMATION FORM

PATIENT NAME: _____

DOB: _____PHONE: _____

Sending Entity	Receiving Entity
SLEEP HEALTH CLINIC PREETHA ROSEN, MD 2501 NE 134TH ST, STE 203 VANCOUVER, WA 98686 Phone: (360) 602-1218 Fax: (360) 991-0291	SLEEP HEALTH CLINIC PREETHA ROSEN, MD 2501 NE 134TH ST, STE 203 VANCOUVER, WA 98686 Phone: (360) 602-1218 Fax: (360) 991-0291
Other:	Other:

Personal Health Information to disclosure

- ☐ History & Physical Examinations
- ☐ Consultation Notes
- ☐ Hospital discharge summary
- ☐ EKG reports
- ☐ ECHO reports
- ☐ Radiology and Imaging Reports
- ☐ Laboratory Reports
- ☐ Medication Records
- ☐ Billing Statements
- ☐ All available record

I may revoke or withdraw my permission in writing at any time, but that will not affect information already produced.

• I understand that, if the recipient of the disclosed PHI isn't an insurance company or physician or provider covered by federal or state privacy laws, the PHI may be re-disclosed by the

recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, STDs, mental health, genetic testing, and chemical dependency information, Federal law may prevent the recipient from re-disclosing this information.
• Notice to those receiving information: If these records contain information about HIV, STDs, or chemical dependency, you may not further disclose PHI under federal and state law without specific permission of the patient (or representative) and meeting specific legal requirements.
• If you are the patient's personal representative, you may be required to provide appropriate documentation to act on behalf of the patient (such as Power of Attorney, Death Certificate, Court order.

Patient/responsible party signature: _____
Date: _____

This form is valid for 90 days from the date of signature.